Form Approved
OMB No. 0938-1213
Appeal Request Form – Individual D

Instructions to help you complete the Marketplace Eligibility Appeal Request

Use the right form to request an appeal

Complete and mail the correct request form for your appeal.

- Use this form in the following states:

Alabama	Louisiana	Tennessee
Alaska	Montana	West Virginia
Arkansas	New Jersey	Wyoming

- Visit **HealthCare.gov/marketplace-appeals** to:
  - Get an appeal request form for other states.
  - Learn more about Marketplace appeals.
- If you have an immediate need for health services and a delay could seriously jeopardize your health, you can ask for an expedited (faster) appeal review. **See Section 4.**
- El Formulario para Apelar la Elegibilidad del Mercado está disponible en español. Para más información visite, **CuidadoDeSalud.gov/es/marketplace-appeals**.
- To appeal Small Business Health Options Program (SHOP) eligibility, visit **HealthCare.gov/marketplace-appeals/shop-decisions/**.

Timeframe to request an appeal

If you applied in one of the states listed above, you must submit your appeal request **within 90 days** of the date on the Marketplace eligibility determination notice that you're appealing.

How to submit this form

Enter your information directly, then print your completed form. Or, print a blank form to fill in by hand using black or dark blue ink.

Sign the completed form and mail to:

Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061

You may also fax the form to a secure fax line: **1-877-369-0130**.

You'll receive all future correspondence about this appeal from the Marketplace Appeals Center. The Marketplace Appeals Center is different from the Health Insurance Marketplace.

What happens next?

1. We'll send you a notice letting you know that we received your appeal request. If there's a problem, like if it's missing information or we need clarification, we'll tell you what's missing and how you can provide additional information.
2. We'll review your appeal, including all documentation you have provided. We may contact you to request additional information or to discuss your appeal.
3. We may ask if you want to resolve your appeal informally. If you're satisfied with your informal resolution, you'll get an informal resolution decision in the mail.
4. If you're not satisfied with your informal resolution, you can ask us to schedule a hearing for your appeal. Most hearings are held over the phone. If you don't attend your hearing, your appeal will be dismissed.
5. After your hearing, you'll get a final appeal decision.

Additional help

Language assistance services
If you need language assistance in a language other than English, you have the right to get help and information in your language at no cost. Call the Marketplace Call Center at 1-800-318-2596.

Accessibility
To request this form in an alternate format like Braille, large print, data CD, audio CD, or to request a qualified reader, you can call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676. You can also make a request by sending a fax to 1-844-530-3676, an email to **AltFormatRequest@cms.hhs.gov**, or a letter to Offices of Hearings and Inquiries (OHI), Attn: CMS Alternate Format Team, 7500 Security Boulevard, Mail Stop S1-13-25, Baltimore, MD 21244-1850. Accommodations are available and provided at no cost to you.

To submit your appeal request, see "How to submit this form" on page 1 of these instructions. If you send your appeal request to the Alternate Format Team address above, your appeal processing may be delayed.

Choose an authorized representative

You have the right to choose an authorized representative to help you with your appeal. This is a trusted person who has your permission to talk with us about your appeal, see your information, and act for you on matters related to your appeal, including getting information about you and signing your appeal request on your behalf.

To appoint an authorized representative, complete and mail the form "Appoint an authorized representative for my appeal," available at **HealthCare.gov/marketplace-appeals/getting-help/**. You can also call the Marketplace Appeals Center to request this form. Even if you already completed an authorized representative form for your Marketplace application, you need to complete an additional form for your appeal.

Questions

If your state isn't listed above, or to learn more about your appeal, call the Marketplace Appeals Center at 1-855-231-1751. TTY users should call 1-855-739-2231. Hours of operation are Monday through Friday, 7:00 a.m. to 8:30 p.m. Eastern Time (ET); and Saturday, 10 a.m. to 5:30 p.m. ET.

Paperwork Reduction Act Disclosure Statement
According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1213. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclaimer** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Marketplace Appeals Center.**

Privacy and Use of Your Information
The Marketplace protects the privacy and security of information about you that you've provided. To view the Privacy Act Statement, go to **HealthCare.gov/individual-privacy-act-statement/**. We're authorized to collect the information on this form and any supporting documentation, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111–152), implementing regulations in 45 CFR part 155, subpart F, and the Social Security Act. For more information about the privacy and security of your information, visit **HealthCare.gov/privacy/**.

Nondiscrimination
The Health Insurance Marketplace doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting **hhs.gov/ocr/civilrights/complaints**, or writing to the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201.

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Enter your information directly, then print and sign your completed form. Or, print a blank form to fill in using black or dark blue ink. Use capital letters and fill in the circles (◯) like this → ●.

SECTION 1: Tell us about the person who's requesting this appeal (also called the "appellant").

1. First name

Middle Name

Last name

Date of birth (mm/dd/yyyy)

Street address

Apartment or suite number

City

State

ZIP code

Daytime phone number

( ) -

If other members of your household are appealing, write their names and dates of birth below. Use extra paper, if necessary. **Note:** The outcome of an appeal could change the eligibility of other members of your household, even if they don't appeal their own eligibility determinations.

2. First name

Middle Name

Last name

Date of birth (mm/dd/yyyy)

3. First name

Middle Name

Last name

Date of birth (mm/dd/yyyy)

4. First name

Middle Name

Last name

Date of birth (mm/dd/yyyy)

SECTION 2: Tell us why you're appealing.

What's the notice date? (mm/dd/yyyy) (Optional)

__ __ / __ __ / __ __ __ __

What's the Application ID # (printed on the first page of the notice)? (Optional)

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Generally, you may appeal the following Marketplace determinations. Check all that apply.

The Marketplace determined that I wasn't eligible for: *(Select statements that apply based on your eligibility notice.)*

- ◯ Health coverage, including Catastrophic coverage
- ◯ Financial assistance (premium tax credits or cost sharing reductions)
- ◯ Medicaid or the Children's Health Insurance Program (CHIP). In your state, the Medicaid or CHIP program may have another name. Go to **HealthCare.gov/downloads/state-programs.pdf** for contact information and a list of state program names if you want to contact your state about your appeals process. To request this appeal, please select one of the following options:
  - ◯ I would like to have my appeal of my denial of Medicaid eligibility heard by the Marketplace Appeals Center, which is the appeals entity for the Health Insurance Marketplace.
  - ◯ I would like to have my appeal of my denial of Medicaid eligibility heard by my state Medicaid agency. The Marketplace will forward this request to my state agency. *(In Wyoming, contact Kid Care CHIP to appeal your eligibility for this program.)*
- ◯ An exemption from paying the fee for not having health coverage (the individual shared responsibility payment)
- ◯ Enrolling in or changing plans through the Marketplace outside a regular Open Enrollment Period

◯ I disagree with the amount of financial assistance (premium tax credits or cost sharing reductions).

◯ The Marketplace didn't provide a timely eligibility determination after I applied for coverage.
(Enter the date of your application, if available.) (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

SECTION 3: Tell us more about why you're requesting this appeal (optional).

Use extra paper if necessary. If you're including documents to support your request, send us one copy of each of your documents. Keep all original documents.

SECTION 4: Ask for a faster appeal if you need one.

If you have an immediate need for health services, and a delay could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, you can ask for an expedited (faster) appeal review.

◯ **I need an expedited appeal.**

Explain the reason you need an expedited appeal. Write the reason for this request in the space below. Use extra paper if necessary. If you're including documents to support your request, send us one copy of each of your documents. Keep all original documents.

SECTION 5: Signature

This information applies for all individuals signing below who are 18 or older.

Your approval to let the Marketplace share federal tax information and Social Security Administration information for use during an appeal.

During your appeal, we may need to share with you or your authorized representative the information the Marketplace used to determine your eligibility. This information might include employment income information from a consumer reporting agency, information about income you receive from the Social Security Administration, and federal tax information from the Internal Revenue Service about members of your household, including information from your last filed federal income tax return. The Marketplace can't share federal income tax information or monthly and annual Social Security Benefit information under Title II of the Social Security Act from the Social Security Administration to an authorized representative or other individuals without your consent. Sign below to give your consent.

I understand by completing, signing, and dating below, I authorize the Marketplace to disclose to the individuals whose signatures are provided below as well as any authorized representative any federal tax information in my eligibility record which was provided by the Internal Revenue Service. I also consent to the release by the Marketplace of my monthly and annual Social Security Benefit information under Title II of the Social Security Act to these same individuals along with other information in my Marketplace eligibility record, collected based on the application I filled out (or was completed for me) or that listed me as a household member, and from other data sources like income and employment verification from a consumer reporting agency that were used to make the Marketplace eligibility determination.

I understand I can request a copy of my Marketplace eligibility appeal record during the appeals process.

Each adult member of the household must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

The authorization is valid until the earlier of:

- The resolution of the appeal; or
- My written notification that I want any or all of my authorized representatives removed from this appeal.

I'm signing this form under penalty of perjury, which means I've provided true answers to all the questions, and I've answered to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false information.

Signature

1. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

Signatures of everyone you listed in Section 1 who's 18 and older

2. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

3. Printed name (First name, Middle name, Last name)

Signature

Date (mm/dd/yyyy)

SECTION 5: Signature (Continued)

4. Printed name (First name, Middle name, Last name)

Signature **Date (mm/dd/yyyy)**

Signatures of any other household members listed on the application for Marketplace coverage
Even if they're not included in this appeal, each adult member of the household who's 18 and older must consent to the disclosure of his or her own federal tax information and also consent to the release of monthly and annual Social Security Benefit information under Title II of the Social Security Act by signing below.

5. Printed name (First name, Middle name, Last name)

Signature **Date (mm/dd/yyyy)**

6. Printed name (First name, Middle name, Last name)

Signature **Date (mm/dd/yyyy)**

7. Printed name (First name, Middle name, Last name)

Signature **Date (mm/dd/yyyy)**

8. Printed name (First name, Middle name, Last name)

Signature **Date (mm/dd/yyyy)**